SOUTH DAKOTA BOARD OF NURSING
SOUTH DAKOTA DEPARTMENT OF HEALTH
4305 S. LOUISE AVENUE SUITE 201 ♦ SIOUX FALLS, SD 57106-3115
(605) 362-2760 ♦ FAX: 362-2768 ♦ www.state.sd.us/doh/nursing

REACTIVATION OF AN INACTIVE NURSING LICENSE

To reactivate your inactivated South Dakota Nursing License, please complete the items listed below and submit them to the South Dakota Board of Nursing. You will be sent a certificate that will be valid from the date of issuance to your second birthday thereafter.

1. A written request to activate your license. You may complete and sign the form below.
2. Declaration/Discipline/Affidavit form: please complete, sign, and submit to Board of Nursing.
3. Verification of Employment form: Provide verification of (a) the minimum number of hours of nursing practice within the last six years, or (b) completion of an approved refresher course.
4. Reactivation Fee of $90. All fees are non-refundable.
5. Inactive Card which was issued to you (if still in your possession).
6. The Nurse Survey Questionnaire.

ADVANCED PRACTICE ALERT:
To practice in South Dakota as a Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Practitioner (CNP), Certified Nurse Midwife (CNM), or a Clinical Nurse Specialist (CNS), you must hold two valid licenses: one as a Registered Nurse, and one as CRNA, CNP, CNM, or CNS.

REQUEST TO REACTIVATE AN INACTIVE NURSING LICENSE

FULL NAME: _____ TEL: _____ EMAIL: _____

ADDRESS: _____
Street or PO Box City State Zip

DATE OF BIRTH: _____ SS#: _____ LICENSE #: _____

I hereby request that my nursing license be returned to Active Status.
I have enclosed the fee of $90 for Reactivation of my nursing license.

APPLICANT SIGNATURE: _____ DATE: _____

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VERIFICATION OF EMPLOYMENT

To obtain/retain active licensure, a nurse must be able to provide verification of at least 140 hours in 12 months ♦ OR ♦ 480 hours in 6 years of employment/volunteer work in nursing.

APPLICANT: COMPLETE THIS SECTION, THEN FORWARD THE FORM TO YOUR EMPLOYER/FORMER EMPLOYER. RETURN THE COMPLETED FORM TO THE SOUTH DAKOTA BOARD OF NURSING.

NAME: _____
First Middle Maiden Last Other Married Names

ADDRESS: _____
Street or PO Box State Zip

SS#: _____ LICENSE #: _____

- ❒ I have been employed/volunteered as a nurse within the last six years.
- ❒ I have not been employed/volunteered as a nurse within the last six years.
- ❒ I choose to apply verification of employment/volunteer work filed at the Board of Nursing within the last six years.

I hereby request and authorize my employer/former employer to release the information requested on this form to the South Dakota Board of Nursing for licensure purposes.

SIGNATURE OF APPLICANT: _____ DATE: _____

THIS SECTION TO BE COMPLETED BY EMPLOYER

The applicant named above was employed/volunteered as a nurse from _____ to _____.
Total hours worked during this period = _____.

I declare and affirm that, according to our records and to the best of my knowledge and belief, the information provided above is true and correct.

SIGNATURE OF AGENCY REPRESENTATIVE/TITLE: _____

NAME OF EMPLOYER: _____

ADDRESS OF EMPLOYER: _____

TELEPHONE: _____ EMAIL: _____ DATE: _____

DISCIPLINARY INFORMATION			
1.	Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or sentence with respect to a felony, misdemeanor, or petty offense other than minor traffic violations? **If YES, provide a signed and dated explanation. You must also submit copies of charges or citations and All communication with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements.**	❒YES	❒NO
2.	Is there any pending criminal prosecution against you which would constitute a felony?	❒YES	❒NO
3.	Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?	❒YES	❒NO
4.	Has any nursing license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action?	❒YES	❒NO
5.	Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?	❒YES	❒NO
6.	Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?	❒YES	❒NO
7.	Have you ever been treated for abuse or misuse of any alcohol or chemical substance?	❒YES	❒NO
8.	Have you ever experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care?	❒YES	❒NO
9.	Do you currently owe child support arrearages in the sum of $1,000 or more?	❒YES	❒NO
For 2-9 above, provide an explanation for each YES response on a separate piece of paper, with a complete description of dates and circumstances. You must also send ALL supporting applicable documents.			

LIST ALL STATES / TERRITORIES / COUNTRIES IN WHICH YOU HAVE BEEN LICENSED AS A NURSE.	LICENSURE TYPE		LICENSE #	ISSUE DATE	EXPIRATION DATE
ORIGINAL STATE OF LICENSURE:	❒RN	❒LP/VN			
CURRENT STATE OF LICENSURE:	❒RN	❒LP/VN			
OTHER STATE:	❒RN	❒LP/VN			
OTHER STATE:	❒RN	❒LP/VN			
OTHER STATE:	❒RN	❒LP/VN			
OTHER STATE:	❒RN	❒LP/VN			

DECLARATION OF PRIMARY STATE OF RESIDENCE – AND – AFFIDAVIT

❒ I declare that my primary state of residence (where I hold a driver's license, pay taxes, and/or vote) is: _____. This is my "home state" under the Nurse Licensure Compact and is my "declared fixed permanent and principal home for legal purposes."

- OR –

❒ I am employed by the federal government, and so am not affected by the Nurse Licensure Compact requirements regarding Primary State of Residence. Name of employer: _____.

I further declare and affirm under penalties of perjury that this application for nurse licensure in South Dakota has been examined by me and, to the best of my knowledge and belief, is in all things true and correct.

Applicant Signature: _____ Date: _____

NURSE SURVEY QUESTIONNAIRE

Please circle **one** number in each of the categories below that best represents your current practice.
Survey Date: _____

Employment Status

1 Full-time Nurse
2 Part-time Nurse
3 Full-time other than nursing
4 Part-time other than nursing
5 Volunteer Nurse
6 Unemployed
7 Retired Nurse

Where Presently Employed:

County _____
State _____
City _____
Zip Code _____

Type of Position

1 Nurse Management
2 Consultant
3 Case Manager
4 Nursing Program Faculty
5 Clinic Nurse
6 Staff Nurse
7 Advanced Practice Nurse (CRNA, CNP, CNM, CNS)
8 Charge Nurse
9 Inservice Educator/Staff Development
10 Other

Formal Education Activities

1 I am not taking courses toward an advanced degree in nursing

2 I am currently taking courses toward an advanced degree in nursing

Advanced Practice Nurses only

1 Certified Registered Nurse Anesthetist (CRNA)
2 Certified Nurse Practitioner (CNP)
3 Certified Nurse Midwife (CNM)
4 Clinical Nurse Specialist (CNS)

Principal Field / Place of Employment

1 Hospital
2 Nursing Home/Long Term Care Facility
3 Nursing Education Program
4 Home Health/Hospice
5 School
6 Outpatient Surgical Center
7 Office/Clinic
8 Community Health
9 Self-employed
10 Other

Highest Degree Held

1 Diploma/Registered Nurse
2 Associate Degree/Registered Nurse
3 Baccalaureate Degree/Registered Nurse
4 Baccalaureate in other Field
5 Masters in Nursing
6 Masters in other Field
7 Doctorate (Ph.D., Ed., D.N.Sc)
8 Diploma/Associate Degree Practical Nurse

What percent of your current position involves direct patient care? (circle one response)

1: 0% 2: 25% 3: 50% 4: 75% 5: 100%

Do you intend to leave/retire from the practice of nursing in the next five years?

1: Yes 2: No

States other than South Dakota in which you are licensed: _____